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	175340	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility identified a census of 186 residents. The sample included 22 residents. Based on observation, record review and interview, the facility failed to provide an ongoing activity program to address the interest of 1 sampled resident (#164) Findings included: - Resident #164's November 2013 electronic record recorded the resident stayed on a secure memory care unit and had a diagnosis of psychosis with behavioral disturbance (any major mental disorder characterized by a gross impairment in reality testing, that may alter an individuals behavior). The 14 day Minimum Data Set 3.0 (MDS) assessment dated 9/14/13 documented the resident had severely impaired cognition, sometimes rejected cares and had daily wandering behavior. The MDS recorded the resident required extensive assistance of two staff with bed mobility and transfers, and extensive assistance of one with dressing, toileting, personal hygiene, eating and ambulating	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 248	Continued From page 1 on and off the unit. Review of the Activity Leisure assessment dated 9/17/13 recorded the residents education level, work history and documented passive activities as the resident watched television and active activities as he/she walked, played pool and rode a stationary bike. The resident's care plan dated 9/19/13 recorded staff were to encourage the resident to participate in games, walks with staff, sit and socialize with staff and other residents, and attend the weekly van ride. The care plan lacked documentation to address the resident's previous life roles/routines (farmer), any specific likes, his/her wandering behavior, group or individual activities, and/or interventions to engage the resident's interest. Observation on the special care unit from 11-18-13 at 9:03 A.M. through 9:35 A.M. revealed staff offered no activities for the residents. Resident #164 and 10 other residents sat in chairs and the TV played music. The residents were not engaged in the music. A staff member started a Wii(electronic game) at 9:50 A.M. and the game remained on but staff did not assist or encourage residents to play the game. Observation on 11/18/13 at 1:00 P.M. revealed resident #164 walked with staff toward his/her own room, turned around and walked back to the activity area (unattended) with his/her right tennis shoe not fully on (shoe heel pushed down in back) and stood unattended in the activity room. Observation on 11/18/13 at 3:30 P.M. revealed the resident walked to his/her room and back to	F 248		

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F 248	Continued From page 2 the activity area and a Bingo activity, but staff did not encourage him/her to participate. Interview on 11/19/13 at 10:10 A.M. direct care staff stated the facility had a Life Enrichment specialist who provided activities on the unit and when he/she was absent it was the responsibility of the direct care staff. Direct care staff O stated, "today (resident and I) worked on his/her truck and we went to the store, got parts and we could not fix it so we had to sell it, " (showed a box of nuts bolts in the activity area). Direct care Staff 0 added that he/she learned of the residents past roles by reading his/her initial assessment." On 11/19/13 at 10:15 A.M. activity staff HH explained how he/she did activities on each of the 7 health care units and the resident did not have any progress notes related to activities in the electronic record because "we generally wait until 90 days of participation before we enter information into the computer." The facility policy titled Activities revised 2006, documented, "activities that stimulate the cardiovascular system and assist with range of motion, such as exercise, movement to music, wheelchair basketball/volleyball, etc, are offered five to seven times a week," and "individualized and group activities, reflect the cultural and religious interest, hobbies, life experiences, and personal preferences of the residents..." The facility failed to provide an ongoing individualized activity program in accordance with the comprehensive assessment to meet the interest, physical, mental, and psychosocial well-being for this cognitively impaired dependent resident.	F 248		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 3 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility identified a census of 186 residents. The sample included 22 residents. Based on observation, record review, and interview the facility failed to develop a comprehensive care plan to address the needs of 3 sampled residents related to activities (#164), pain (#43) and behavior monitoring, (#196). Findings included: - Resident #164's November 2013 electronic medical record stated the resident stayed on a secure memory care unit with a diagnosis of psychosis with behavioral disturbance (any major mental disorder characterized by a gross	F 279		

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F 279	Continued From page 4 impairment in reality testing, that may alter an individuals behavior). The 14 day Minimum Data Set 3.0 (MDS) assessment dated 9/14/13 documented the resident had severely impaired cognition, sometimes rejected care and had daily wandering behaviors. The MDS recorded the resident required extensive assistance of two staff members with bed mobility and transfers and extensive assistance of one staff member with dressing, toileting, personal hygiene, eating and ambulating on and off the unit. Review of the activity leisure assessment dated 9/17/13 recorded the residents education level, work history and documented passive activity he/she watched television, and listed active activity he/she walked, played pool, and rode a stationary bicycle. The residents care plan dated 9/19/13 recorded, to encourage the resident to participate in games, walk with staff, to sit and socialize with staff and other residents, and attend the weekly van ride. The care plan lacked documentation to address the resident's previous life roles/routines (farmer) any specific likes, his/her wandering behavior, group or individual activities, and/or interventions to engage the resident's interests of pool and or a stationary bicycle. Observation on 11/18/13 at 1:00 P.M. revealed the resident walked with staff toward his/her own room, turned around and walked back to the activity area (unattended) with his/her right tennis shoe not fully on (shoe heel pushed down in back). The resident stood unattended in the activity room.	F 279		

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F 279	Continued From page 5 Interview on 11/19/13 at 4:00 P.M. with administrative licensed nurse D stated the residents care plans should reflect their individual needs. The facility policy titled Care Plan-Comprehensive revised 2010, lacked documentation to identify the residents previous life roles and/or address any specific activities the resident enjoyed, specific locations and treatment interventions for residents who experience pain. The facility failed to develop a comprehensive, individualized care plan related to acivities for this cognitively impaired dependent resident. - Resident #43's November 2013 electronic medical record stated the resident stayed on a secure memory care unit and had diagnosis of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and muscle spasms (an involuntary muscular movement or contraction). The annual Minimum Data Set 3.0 (MDS) assessment dated 10/31/13 documented the resident with a Brief Interview for Mental Status score of 4 which indicated the resident had severely impaired cognition. The MDS recorded the resident required extensive assistance of one to two staff members with bed mobility, transfers, toileting, dressing and most activities of daily living. The MDS recorded the resident had an indwelling Foley catheter, and occasionally complained of severe pain. The Care Area Assessment dated 10/31/13 for pain recorded the resident's pain affected his/her	F 279		

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activity level, but not sleep, and identified knee and leg pain after walking.

The residents care plan dated 11/12/13 recorded, the residence had potential for pain related to minor aches and pain, headaches, and generalized pain related to osteoarthritis (inflammation in bone joint).

The care plan lacked documentation to address pain associated with the residents bladder and/or indwelling catheter.

During a resident interview on 11/13/13 at 1:09 P.M. observation revealed the resident became agitated, attempted to reposition his/herself in the chair and exclaimed "Ooh, Ouch, Ouch". Licensed nurse H responded and explained the resident suffered from bladder spasms, for which he/she received medication.

On 11/13/13 at 3:00 P.M. licensed nurse M stated the location, intensity and treatment interventions should be included on the residents care plan.

The facility policy titled Care Plan-Comprehensive revised 2010, lacked documentation for an individualized approach to resident care plans that addressed specific types of pain and/or interventions.

The facility failed to develop a comprehensive, individualized care plan that included the location and treatment for this cognitively impaired, dependent resident who experienced pain.

- Resident #196's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-17-13 documented the resident with short and long term memory loss and severe cognitive impairment.

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The resident required extensive assistance of staff with activities of daily living (ADLs) and limited assistance of staff with eating. The resident had physical and verbal behaviors toward others, wandered, and rejected cares on a daily basis.

The Cognition Care Area Assessment (CAA) dated 7-24-13 documented the resident with a brain tumor, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure) or other dementia (progressive mental disorder characterized by failing memory, confusion).

The Behavior CAA dated 7-24-13 documented the resident had a couple of episodes of physical aggression and wandered on the unit daily, going into other resident rooms.

The Psychotropic drug use CAA dated 7-24-13 documented the resident received Ativan (an antianxiety medication) as needed (PRN) for anxiety and agitation.

The 10-15-13 care plan documented the resident had inappropriate behavior, resisted care and treatment, was able to state his/her needs, and at times was able to follow simple directions. Interventions directed staff to encourage the resident to participate in activities of interest such as watch or listen to the tv, music, worship services, pet visits, and the resident liked to spend time outside. The resident lowered him/herself to the floor, grabbed and hit staff with cares. The care plan directed staff to inform the resident of cares prior to performing them, offer praise and positive reinforcement after care. The care plan documented if the resident resisted care, reapproach the resident later, or have

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different staff approach the resident, or try to redirect the resident.

The 10-15-13 care plan documented the resident resided on a secured unit, wandered on the unit without purpose, and had impaired judgement. The care plan documented the resident wore a code alert bracelet (an electronic device used to protect people when they were at risk for wandering).

The 10-15-13 care plan identified the resident at risk for injury related to falls, as the resident tried to prevent falling by getting on the floor and crawled around. Staff anticipated the resident's needs. The care plan directed staff to speak slow to the resident, allow the resident time to respond and perform cares into manageable subtasks.

Record review of the November 2013 Behavior Monitoring Sheet documented the resident's targeted behaviors as hitting and yelling at staff. Interventions included redirection and reapproach the resident with in 15 minutes. The sheet documented the resident had the behaviors frequently during the month.

On 7-21-13 at 11:30 A.M. the nurse's note (NN) documented staff heard the resident yell, went to a resident's room and found resident #196 in another resident's room. The resident held onto the other residents wheelchair handles. The other resident informed staff he/she slapped resident #196.

On 7-23-13 at 11:30 A.M. the NN documented staff attempted to assess the resident's left foot and the resident became agitated, grabbed the writer by the neck and dug his/her nails into staffs

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skin. Staff re-applied the sock and the resident propelled self in his/herself in the wheelchair.

On 7-30-13 at 9:00 A.M. the care plan summary documented the resident received medication for anxiety, wandered on the unit most of the time, transferred his/herself in wheelchair, became agitated, swatted, and pinched staff with cares. Staff would continue to monitor the resident's behaviors.

On 8-11-13 at 9:45 P.M. the NN documented staff responded to the resident's alarm and while attempting to provide care, the resident became agitated, slapped, and pinched staff. The intervention included redirection, staff transferred the resident into his/her chair, and provided a baby doll for the resident.

On 11-13-13 at 4:12 P.M. the care plan summary note documented staff reviewed the resident's medications, the resident's spouse felt the resident had pain in his/her mouth due to sores, and tended to become agitated when staff transferred him/her. The resident attended some activities and liked to go outdoors.

On 11-18-13 at 8:59 A.M. direct care staff O and P took the resident to his/her room, placed a gait belt around the resident and lifted the resident to place a small pillow under his/her left hip. The resident hollered "no, no" during the transfer and tried to grab at anything he/she was able to get hold of. Direct care staff P held the resident's hands and the resident tapped direct care staff P's hands as if he/she was slapping them. Staff provided a baby doll to the resident after placing him/her back in the wheelchair. Staff placed the resident in the living area and the resident sat in

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his/her wheelchair, held the baby doll and closed his/her eyes.
On 11-18-13 at 9:14 A.M. the resident propelled his/her wheelchair in the living area and ran over another residents foot and the other resident said "ouch" . The resident continued to propel his/her wheelchair and bumped into another resident's wheelchair. Staff removed the other resident from the area.

On 11-18-13 at 2:07 P.M. the resident wandered into another resident's room. Staff walked by the room, noticed the resident and removed him/her from the room.

On 11-18-13 at 9:03 A.M. during interview, direct care staff O stated the resident usually grabs at things, and was resistive to cares. He/she stated they stopped the care and came back later to re-approach the resident. He/she stated they did place objects such as stuffed animals in the resident's hands at times to prevent him/her from grabbing staff.

On 11-18-13 at 1:45 P.M. during interview, direct care staff P stated staff had care sheets that directed the care they gave to residents. He/she stated he/she usually worked the night shift and the resident often hit staff when he/she was agitated and even if the resident did not have his/her mind, he/she had a right to refuse care, but was usually cooperative.

On 11-18-13 at 2:36 P.M. during interview, direct care staff Q stated during the evening the resident was resistive to care, grabbed, and hit at staff but if they left and came back the resident was cooperative.

On 11-18-13 at 9:37 A.M. during interview,

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administrative nurse F stated the resident was usually happy, chipper, and cooperative with cares and did not resist care.

On 11-18-13 at 3:23 P.M. during interview, licensed nurse H stated the resident became agitated, grabbed staff during cares and staff attempted to talk to the resident to calm him/her, reapproached, and if they felt the agitation was due to pain, provided pain medication. He/she stated he/she updated care plans with changes.

On 11-19-13 at 10:14 A.M. during interview, activity staff HH stated staff invited the resident to attend group activities, and provided sensory stimulation because the resident liked to touch things. He/she stated the resident had a very short attention span and if staff observed the resident wandering, then staff engaged the resident in an activity.

On 11-19-13 at 12:50 P.M. during interview, administrative nurse E stated he/she was in the process of assessing the resident for a significant change care plan. He/she stated he/she did not develop the resident's care plan, but was involved in updating the care plan. He/she stated staff identified concerns with the resident's behavior and often staff redirected the resident.

The October 2010 facility provided Care Plan Policy and Procedure documented staff individualized the comprehensive care plan to meet the residents' needs, was ongoing, and revised as the resident's condition changed.

The facility failed to develop a comprehensive care plan to include appropriate interventions when the resident displayed agitation and behaviors.

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F 280 SS=D	Continued From page 12 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 186 residents. The sample included 22 residents. Based on observation, interview, and record review the facility failed to revise and revise the care pan to reflect changes in the resident care for pressure ulcers, urinary incontinence, and falls for 3 of 22 residents reviewed. (#196, #164, #236) Findings included: - Resident #196's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-17-13 documented the resident with short and long term memory loss and severe cognitive impairment.	F 280		

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F 280	Continued From page 13 The resident required extensive assistance of staff for assistance with activities of daily living (ADLs) and limited assistance of staff with eating. The resident was incontinent of bowel and bladder, had physical and verbal behaviors toward others, wandered and rejected cares on a daily basis, and was at risk for the development of pressure ulcers. The 8-8-13 Pressure Ulcer Care Area Assessment (CAA) documented the resident did not have any current skin breakdown, but was at risk due to his/her age, incontinence and diminished mobility. The resident repositioned his/herself, wore incontinent products that wicked away moisture, and had pressure reducing devices in his/her bed and wheelchair. The Urinary Incontinence Care Area Assessment (CAA) dated 7-24-13 documented the resident was incontinent, was on a prompting program but was changed to a habit program (a toileting program which consisted of regular trips to the bathroom to avoid accidents), and wore pull up briefs. On 11-7-13 the care plan documented the resident with a stage 3 pressure ulcer on his/her left hip. Interventions included the following: Ensure the resident's nails were kept trimmed to avoid unintentional skin tears from scratching. Obtain laboratory/diagnostic work as ordered and follow up as indicated. The resident wore incontinent products that wicked moisture away from the skin.	F 280		

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Remind and assist the resident to reposition at least every one to two hours if not doing it on his/her own.

Observe for edema and report to the nurse.

Provide wound rounds with the wound nurse and provide weekly ulcer report.

Reposition the resident every one to two hours and consider a Broda (a special type chair used to redistribute pressure on the buttocks) chair.

11-8-13 an intervention to use Exoderm (a specialized dressing for wounds) dressing to the open areas on the resident's left hip, and changed the dressing every 5 days and PRN.

11-12-13 an intervention to discontinue the previous treatment to the left hip and provide Collagen (a specialized product to promote wound healing) treatment to the wound with a hydrocolloid (a specialized product to promote wound healing) dressing, change the dressing every 7 days and as needed (PRN). The care plan directed staff to offload this site as much as possible while the resident was in his/her chair.

The 10-25-13 care plan documented the resident was at risk for functional, stress, urge and overflow urinary incontinence. The resident was also at risk for frequency, retention, urinary tract infections (UTI) related to his/her dementia (progressive mental disorder characterized by failing memory, confusion) and a meningioma (benign brain tumor). The care plan documented the resident alerted staff occasionally when he/she needed to toilet and participated in his/her toileting program. The care plan directed staff to toilet the resident when he/she tried to get up

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without assistance, and respond quickly when the personal alarm sounded to assist with toileting needs. The care plan documented the resident told staff when he/she needed to "tee, tee", which meant he/she needed to toilet. The care plan directed staff to check and change the resident every 2 hours.

Observation on 11-18-13 at 8:10 A.M. revealed the resident sat in his/her high back wheelchair and had a yellow gel type cushion on the wheelchair. The resident sat at the dining table. The resident had scrambled eggs, 2 pieces of bacon, a slice of toast with butter and jelly cut in half, and 2 tall glasses with screw top lids and hard plastic straws. Both glasses were filled approximately one third of the way with fluid. The resident managed to unscrew the lid from one glass and spilled the liquid on the table and the floor. Direct care staff P cleaned the table and floor, and removed the glass from the table. Staff did not refill the glass or provide assistance with the resident's meal.

Observation on 11-18-13 at 8:59 A.M. revealed direct care staff O and P took the resident to his/her room, placed a gait belt around the resident and lifted the resident to place a small pillow under his/her left hip. Direct care staff O stated it was to relieve pressure because the resident had a sore on his/her bottom.

Observation on 11-18-13 at 2:15 P.M. revealed direct care staff O and Q transferred the resident from his/her wheelchair to the bed. Direct care staff Q removed the resident's pants and brief and revealed the resident's perineal area red and inflamed. Staff provided perineal care and put "Clear Moisture Barrier" cream on the resident. At this time, direct care staff Q stated they were

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supposed to put it on the resident with each incontinence episode.

On 11-18-13 at 2:36 P.M. during an interview, direct care staff P stated the resident was not able to state his/her toileting needs or follow directions and staff checked and changed the resident every 2 hours.

On 11-18-13 at 3:23 P.M. during interview, licensed staff H stated the resident was not able to state his/her needs and at one time the resident was able to state when he/she needed to go to the bathroom and would say "tee, tee", but no longer said it, so staff anticipated the resident's needs and provided toileting every 2 hours. He/she stated prior to the development of the pressure ulcers, the resident ambulated with a walker at times, had a reclining chair and received restorative services following therapy. He/she stated the resident had not ambulated since his/her last day of therapy on 7-9-13, but restorative provided range of motion to the resident's extremities. He/she stated staff placed a pillow under the resident's left hip while up in the wheelchair, to offload pressure.

On 11-18-13 at 3:41 P.M. during interview, licensed nurse I stated staff placed a pillow under the resident's hip to offload the pressure when the resident was up in his/her wheelchair.

On 11-19-13 at 3:50 P.M. during an interview, administrative nurse F stated staff placed the resident in a Broda chair yesterday and it belonged to the facility. He/she stated the resident had a cushion in the other chair also for pressure reduction. He/she stated the resident

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had predisposing factors that made the resident high risk for the development of pressure ulcers that included the use of diuretic medication and steroid medication for the treatment of the resident's cancer. He/she stated the resident had increased incontinence with the use of the diuretic medication and the resident was continuously incontinent.

The October 2010 facility provided Care Plan Policy and Procedure documented staff individualized the comprehensive care plan to meet the residents' needs, was ongoing, and revised as the resident's condition changed.

The facility failed to review and revise the care plan to include specific interventions to reflect interventions of the pillow to offload pressure on the resident's wounds, failed to address the resident's frequent incontinent needs, failed to provide interventions to address the resident's inflamed perineum, and the resident's inability to state his/her toileting needs.

- Resident #164's November 2013 electronic record recorded the resident stayed on a secure memory care unit and had a diagnosis of psychosis with behavioral disturbance (any major mental disorder characterized by a gross impairment in reality testing that may alter an individuals behavior)
The 14 day Minimum Data Set 3.0 (MDS) assessment dated 9/14/13 documented the resident had severely impaired cognition, sometimes rejected cares and had daily wandering behavior. The MDS recorded the resident required extensive assistance two staff with bed mobility and transfers and extensive

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assistance of one with dressing, toileting, personal hygiene, eating and ambulating on and off the unit. The MDS did not address the resident fall history.

The Care Area Assessment (CAA) dated 9/6/13 recorded the resident had one fall since admission and staff found him/her crawling in a peers room, staff placed the resident on the physician a list for medication review and he/she was at continued risk due to medical diagnoses.

Review of the resident's initial fall assessment dated 8/30/13 recorded the resident with a score of 20, which indicated the resident was at high risk for falls.

Review of the clinical record and fall investigations revealed the resident experienced non-injury falls on 9/3/13, 10/23/13, 10/24/13, 10/29/13, 10/31/13, 11/2/13, 11/6/13, 11/12/13, and 11/16/13.

The resident's care plan dated 9/19/13 recorded the resident was at risk for falls and directed staff to assist resident with ambulation when he/she was feeling weak, assist the resident to bed last when he/she was ready, and an intervention dated 11/13/13 for a personal safety alarm when in bed.

The care plan lacked documentation the resident used a low bed with a right side landing mat, the use of non slip socks at all times, and 15 minute checks, (as noted on the fall investigation reports dated 10/29/13, 11/12/13 and 11/16/13 respectively).

Observation on 11/18/13 at 1:00 P.M. of the resident revealed he/she walked with staff toward

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his/her own room, turned around and walked back to the activity area (unattended) with his/her right tennis shoe not fully on (shoe heel pushed down in back).

On 11/19/13 at 10:24 A.M. licensed nurse J stated care plans were revised regularly and during the residents care plan meetings.

The facility policy titled Care Plans-Comprehensive dated 2010 recorded assessments of residents are ongoing and care plans were revised as information about the resident and the residents condition change.

The facility failed to revise the resident's care plan to accurately reflect the current plan of care for his resident regarding falls and fall interventions.

- The 9-16-2013 quarterly Minimum Data Set (MDS) for resident #236 displayed the Brief Interview for Mental Status (BIMS) of 9 which indicated the resident's cognition was moderately impaired. The resident was not on a current toileting program, was frequently incontinent of urine, and received diuretic medication daily during the last seven days.

The care plan for incontinence dated 9-24-2013 documented staff to provide 1:1 assistance with perineal care and staff to prompt toileting every 2 hours and as needed.

Record review revealed bladder training flowsheet dated 6-28-13 to 6-30-13 documented the resident was incontinent of urine.

Observation on 11-18-13 at 9:44 A.M. revealed

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the resident took him/her self to the bathroom. At 1:53 P.M. the resident took him/her self the the bathroom and had on new clothes. Continuous observation from 1:53 P.M. to 4:15 P.M. revealed staff did not prompt the resident to use the bathroom or provide perineal care for the resident.

Interview on 11-19-13 at 9:42 A.M. with direct care staff R revealed staff did check on the resident for incontinence every two hours.

Interview on 11-19-13 at 9:50 A.M. with direct care staff S revealed the resident toileted himself/herself independently yet if he/she saw the resident go into the restroom, he/she needed checked on. The resident was incontinent of bladder most of the time and needed assist and with perineal care. Direct care staff S stated he/she, usually checked on the resident every two to three hours.

Interview on 11-19-13 at 10:42 A.M. with licensed staff J revealed the resident took care of his/her incontinence needs. The resident wore a pullup and he/she changed the disposable brief. The resident provided his/her own perineal care. Staff should check and change the resident every two hours and should prompt him/her to use the toilet. At 12:40 P.M. licensed staff J stated care plans were updated all the time and reviewed at care plan meetings.

Interview on 11-19-13 at 12:42 P.M. with licensed staff K revealed care plans were updated anytime something changes. The care plans were to reflect the individual needs of the resident. The resident was independent with toileting and he/she did his/her own perineal care and changed his/her incontinence products. Licensed

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F 280	Continued From page 21 staff K acknowledged the resident's care plan was not specific to his/her individual needs. Interview on 11-19-13 at 4:00 P.M. with administrator nursing staff D revealed the resident's care plan needed to reflect the resident's individual needs and said he/she would check on that. The facility provided October 2010 comprehensive care plan policy displayed assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition changed. The facility failed to update the care plan to address the individual needs of this resident regarding toileting and incontinence care.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility identified a census of 186 residents. The sample included 22 residents. Based on observation, interview, and record review the facility failed to provide effective interventions to address the resident's agitation and anxiety when staff provided cares. (#196) Findings included:	F 309		

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F 309	Continued From page 22 - Resident #196's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-17-13 documented the resident with short and long term memory loss and severe cognitive impairment. The resident required extensive assistance of staff with activities of daily living (ADLs) and limited assistance of staff with eating. The resident had physical and verbal behaviors toward others, wandered and rejected cares on a daily basis. The Behavior CAA dated 7-24-13 documented the resident had a couple of episodes of physical aggression and wandered on the unit daily, going into other resident rooms. The Psychotropic drug use CAA dated 7-24-13 documented the resident received Ativan (an antianxiety medication) as needed (PRN) for anxiety and agitation. The Cognition CAA dated 7-24-13 documented the resident with a brain tumor, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure) or other dementia (progressive mental disorder characterized by failing memory, confusion). The 10-15-13 care plan documented the resident had inappropriate behavior, resisted care and treatment, was able to state his/her needs, and at times was able to follow simple directions. Interventions directed staff to encourage the resident to participate in activities of interest such as watch or listen to the tv, music, worship services, pet visits, and he/she liked to spend time outside. The resident lowered him/herself to the floor, grabbed and hit staff with cares. The care plan directed staff to inform the resident of cares prior to performing them, offer praise and	F 309		

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positive reinforcement after care. The care plan documented if the resident resisted care, reapproach the resident later, or have different staff approach the resident, or try to redirect the resident.

The 10-15-13 care plan documented the resident resided on a secured unit, wandered on the unit without purpose, and had impaired judgement. The care plan documented the resident wore a code alert bracelet (an electronic device used to protect people when they were at risk for wandering).

The 10-15-13 care plan identified the resident at risk for injury related to falls, as the resident tried to prevent falling by getting on the floor and crawled around. Staff anticipated the resident's needs. The care plan directed staff to speak slow to the resident, allow the resident time to respond and provide cares into manageable subtasks.

Record review of the November 2013 Behavior Monitoring Sheet documented the resident's targeted behaviors as hitting and yelling at staff. Interventions included redirection and reapproach the resident within 15 minutes. The sheet documented the resident had the behaviors frequently during the month.

On 7-21-13 at 11:30 A.M. the nurse's note (NN) documented staff heard the resident yell, went to a resident's room and found resident #196 in another resident's room. The resident held onto the other residents wheelchair handles. The other resident informed staff he/she slapped resident #196.

On 7-23-13 at 11:30 A.M. the NN documented

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F 309	Continued From page 24 staff attempted to assess the resident's left foot and the resident became agitated, grabbed the writer by the neck and dug his/her nails into staffs skin. Staff re-applied the sock and the resident propelled self in his/herself in the wheelchair. On 7-30-13 at 9:00 A.M. the care plan summary documented the resident received medication for anxiety, wandered on the unit most of the time, transferred his/herself in wheelchair, became agitated, swatted, and pinched staff with cares. Staff would continue to monitor the resident's behaviors. On 8-11-13 at 9:45 P.M. the NN documented staff responded to the resident's alarm and while attempting to provide care, the resident became agitated, slapped, and pinched staff. The intervention included redirection, staff transferred the resident into his/her chair, and provided a baby doll for the resident. On 8-2-13 at 10:09 P.M. the NN documented the resident slapped staff when attempting to provide toileting. On 10-15-13 at 3:14 P.M. the activity progress note documented the resident propelled in his/her wheelchair most of his/her day, participated in activities that included current events, ball toss, music, bingo, and going outside. Staff encouraged the resident to attend activities of interest. On 11-13-13 at 4:12 P.M. the care plan summary note documented staff reviewed the resident's medications, the resident's spouse felt the resident had pain in his/her mouth due to sores, and tended to become agitated when staff	F 309		

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transferred him/her. The resident attended some activities and liked to go outdoors.

The record documented the resident with frequent falls, and resistance to cares several times weekly. The record lacked evidence staff attempted different approaches to address the resident's agitation and refusal of care.

observation on 11-18-13 at 8:10 A.M. revealed the resident sat in his/her high back wheelchair and had a yellow gel type cushion on the wheelchair. The resident sat at the dining table. The resident had scrambled eggs, 2 pieces of bacon, a slice of toast with butter and jelly cut in half, and 2 tall glasses with screw top lids and hard plastic straws. Both glasses were filled approximately one third of the way with fluid. The resident managed to unscrew the lid from one glass and spilled the liquid on the table and the floor. Direct care staff P cleaned the table and floor, and removed the glass from the table. Staff did not refill the glass or provide assistance with the resident's meal.

On 11-18-13 at 8:15 A.M. the resident would take a bite of toast or bacon then fiddle with everything on the table. The resident attempted to get a drink from the glass, but was not able to maneuver it to his/her mouth to get a drink.

On 11-18-13 at 8:20 A.M., 8:25 A.M., 8:30 A.M., 8:35 A.M., 8:40 A.M., and 8:45 A.M., the resident continued to play with everything on the table. At 8:46 A.M. the resident made multiple attempts to tip the glass to drink from it, but was unable . At 8:52 A.M. dietary staff informed the resident they would take his/her napkin and place it in a bag. The resident spilled the food remaining on his/her plate. The resident spilled food from his/her plate

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F 309	Continued From page 26 and the plate was empty. On 11-18-13 at 8:55 A.M. direct care staff O informed the resident he/she was going to move the resident from the table. As direct care staff O attempted to move the resident, he/she grabbed to hold onto the table and when away from the table grabbed at another chair. Direct care staff O held the resident's hands to prevent him/her from grabbing anything else and positioned the resident in the living area. Observation on 11-18-13 at 8:59 A.M. direct care staff O and P took the resident to his/her room, placed a gait belt around the resident and lifted the resident to place a small pillow under his/her left hip. The resident hollered "no, no" during the transfer and tried to grab at anything he/she was able to get hold of. Direct care staff P held the resident's hands and the resident tapped direct care staff P's hands as if he/she was slapping them. Staff provided a baby doll to the resident after placing him/her back in the wheelchair. Staff placed the resident in the living area and the resident sat in his/her wheelchair, held the baby doll and closed his/her eyes. Observation on 11-18-13 at 9:03 A.M. revealed the resident and 11 other cognitive impaired residents sat in the living area. The tv was on and played music. None of the residents were engaged in any type activity and sat in chairs. On 11-18-13 at 9:14 A.M. observation revealed the resident propelled his/her wheelchair in the living area and ran over another residents foot and the other resident said "ouch" . The resident continued to propel his/her wheelchair and bumped into another resident's wheelchair. Staff removed the other resident from the area.	F 309		

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F 309	Continued From page 27 Observation on 11-18-13 at 9:35 A.M. direct care staff O started a bowling video game on tv and played the game. One resident was engaged and visited with direct care staff O, but residents were not encouraged to participate in the game. On 11-18-13 at 1:01 P.M. observation revealed the resident sat in his/her high back wheelchair with a gel cushion. Direct care staff P sat beside the resident and attempted to feed the resident. The resident refused and played with the food and napkin. Direct care staff P handed the resident a tall glass with a screw top lid and hard plastic straw and the resident was not able to suck from the straw. Dietary staff removed the resident's plate with direct care staff P's permission. Direct care staff P did not offer the resident an alternate and did not assist the resident with his/her fluids at this time. When direct care staff P removed the resident from the table, the resident attempted multiple times to grab for the table. Observation on 11-18-13 at 2:07 P.M. revealed the resident wandered into another resident's room. Staff walked by the room, noticed the resident and removed him/her from the room. On 11-18-13 at 3:10 P.M. observation revealed 2 residents sat at a table and 1 staff member assisted them with bingo. Resident #196 was not engaged in the game. Eight other residents sat in chairs in the living area and were not engaged in any type of activity. On 11-18-13 at 1:45 P.M. during interview, direct care staff P stated staff had care sheets that directed the care they gave to residents. He/she stated he/she usually worked the night shift and	F 309		

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the resident often hit staff when he/she was agitated and even if the resident did not have his/her mind, he/she had a right to refuse care, but was usually cooperative.

On 11-18-13 at 2:36 P.M. during interview, direct care staff Q stated during the evening the resident was resistive to care, grabbed, and hit at staff but if they left and came back the resident was cooperative. He/she stated two direct care staff were on the unit on the day and evening shift.

On 11-18-13 at 9:37 A.M. during interview, administrative nurse F stated the resident was usually happy, chipper, and cooperative with cares and did not resist care.

On 11-18-13 at 3:23 P.M. during interview, licensed nurse H stated the resident became agitated, grabbed staff during cares and staff attempted to talk to the resident to calm him/her, reapproached, and if they felt the agitation was due to pain, provided pain medication.

On 11-19-13 at approximately 10:00 A.M. during an interview, direct care staff O stated they provided the activities for the resident's when the activity staff was not on the unit. He/she stated they usually had 2 direct care staff on the unit to provide care for the residents and provide the activities.

On 11-19-13 at 10:14 A.M. during interview, activity staff HH stated staff invited the resident to attend group activities, and provided sensory stimulation because the resident liked to touch things. He/she stated the resident had a very short attention span and if staff observed the resident wandering, then staff engaged the

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F 309	Continued From page 29 resident in an activity. He/she stated one activity assistant provided activities between two units and direct care staff engaged the residents in activities as much as possible. The 2-19-13 facility provided Behavior Assessment and Monitoring Policy and Procedure documented staff monitored and managed residents with problematic behaviors appropriately. The facility failed to provide ongoing, effective interventions to address the resident's agitation and resistance to cares.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility identified a census of 186 residents. The sample included 22 residents. Based on observation, interview, and record review the facility failed to prevent the development of pressure ulcers, and failed to provide timely interventions after the development of pressure ulcers for 3 of 4 residents reviewed for pressure ulcers. (#196, #53, #222) Findings included:	F 314		

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F 314	Continued From page 30 - Resident #196's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-17-13 documented the resident with short and long term memory loss and severe cognitive impairment. The resident required extensive staff assistance with activities of daily living (ADLs) and limited assistance of staff with eating. The resident was incontinent of bowel and bladder, had physical and verbal behaviors toward others, wandered and rejected cares on a daily basis. The resident did not have any pressure ulcers, but was at risk for the development of a pressure ulcer. The 8-8-13 Pressure Ulcer Care Area Assessment (CAA) documented the resident did not have any current skin breakdown, but was at risk due to his/her age, incontinence and diminished mobility. The resident repositioned him/herself, wore incontinent products that wicked away moisture, and had pressure reducing devices in his/her bed and wheelchair. The Cognition CAA dated 7-24-13 documented the resident had a brain tumor, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure) or other dementia (progressive mental disorder characterized by failing memory, confusion). The 10-13-13 Braden Assessment (a rating scale to determine a resident's risk for development of a pressure ulcer. The lower the score, (the lower the level of functioning which indicated a higher risk for the development of a pressure ulcer) documented the resident's skin was occasionally moist, and required an extra linen change approximately once daily. The resident walked occasionally during the day, short distances and spent most of his/her time in his/her bed or chair. The assessment	F 314		

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documented the resident was able to move in his/her bed and chair independently and had sufficient muscle strength to lift his/herself up. The total score was 19, which indicated the resident was not at risk for the development of a pressure ulcer.

The 10-17-13 care plan documented the resident at risk for the development of pressure ulcers and documented the following interventions:

Treatment and dressing changes as directed.

Monitor for signs/symptoms of improvement/deterioration and wound status.

Provide a pressure redistributing mattress to the bed.

Position the resident off the affected side as much as possible.

Provide pain relief, coordinate painful dressing changes, therapies or procedures by providing medication as prescribed.

Provide nutritional support.

Obtain laboratory/diagnostic work as ordered and follow up as indicated.

Refer to the non temporary skin/pressure care plan for further preventive measures.

On 11-7-13 the updated care plan documented the resident had a stage 3 pressure ulcer on his/her left hip. Interventions included the following:

Ensure the resident's nails were kept trimmed to

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F 314	Continued From page 32 avoid unintentional skin tears from scratching. Obtain laboratory/diagnostic work as ordered and follow up as indicated. The resident wore incontinent products that wicked moisture away from the skin. Remind and assist the resident to reposition at least every one to two hours if not doing it on his/her own. Observe for edema and report to the nurse. Provide wound rounds with the wound nurse and provide weekly ulcer report. Reposition the resident every one to two hours and consider a Broda (a special type chair used to redistribute pressure on the buttocks) chair. On 11-8-13 the care plan was updated to use Exoderm (a specialized dressing for wounds) dressing to the open areas on the resident's left hip, and change every 5 days and PRN. On 11-12-13 the care plan was updated to discontinue the previous treatment to the left hip and provide Collagen (a specialized product to promote wound healing) treatment to the wound with a hydrocolloid (a specialized product to promote wound healing) dressing, change the dressing every 7 days and as needed (PRN). The care plan directed staff to offload this site as much as possible while the resident was in his/her chair. On 11-2-13 the Risk Assessment form documented the resident's groin area was pink and staff applied a moisture barrier cream.	F 314		

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F 314	Continued From page 33 On 11-6-13 the Risk Assessment form documented the resident developed two half centimeter (cm) open areas on his/her left hip. On 11-9-13 the Risk Assessment form documented the resident's groin was pink. Staff provided perineal care and a moisture barrier cream. The assessment lacked documentation of the two pressure ulcers on the resident's left hip. On 11-16-13 the Risk Assessment form documented the resident's groin area was pink, staff provided perineal care and applied moisture barrier cream. The assessment lacked documentation of the two pressure ulcers on the resident's left hip. On 11-5-13 at 3:04 P.M. the nutrition note documented the resident received Magic Cup (a fortified nutritional supplement) daily, Med Pass (a fortified nutritional supplement) 2.0, 60 milliliters (ml) twice daily, had good acceptance of the supplements and did not have weight loss. On 11-6-13 at 9:57 P.M. the nurse's note (NN) documented the resident had two one half cm open areas on the resident's left lower hip. Staff applied Mepilex dressing (a specialized moisture absorption dressing) on the open areas. On 11-12-13 the Wound Report documented the resident with a left hip ischial (the lower and back part of the hip bone) wound. The Pressure Ulcer Scale for Healing (PUSH) tool documented the resident's wound score of 4, which indicated the resident's wounds length by (x) width measured 1.1 x 2.0 centimeters (cm).	F 314		

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F 314	Continued From page 34 On 11-12-13 the wound record documented the resident had 2 areas on his/her left hip and together the wounds measured 2.4 cm length (L) x 0.4 cm width (W) x 0.1 cm depth (D). The resident complained of pain with touch, had unattached wound margins and the current treatment included collagen with a hydrocolloid dressing changed every 7 days and to offload the area with a pillow while the resident was in his/her wheelchair. On 11-18-13, the wound care physician saw the resident and documented the resident with two stage 3 to unstageable pressure ulcers on the resident's left hip/ischial area. The resident received Med Pass twice daily and Magic cup daily. The resident started a multi vitamin today. The resident's dietary intake was 75%. One wound measured 0.9 cm x 0.6 cm, was a stage 3 to unstageable wound and the other measured 0.9 cm x 0.7 cm and was a stage 3 to unstageable wound. The physician documented the resident's periwound (the skin that surrounded the ulcers) was erythematous (red, inflamed) rash with yeast and needed to be cleared prior to treating the pressure ulcers. He/she ordered an antifungal ointment. The physician documented staff was unable to keep a dressing in place due to the resident's constant incontinent episodes. Record review of the laboratory results on 6-3-13 included the resident's protein (a blood test to measure the amount of protein in the blood to determine a person's nutritional status) level was 5.3 grams per deciliter (g/dl) which was low. The normal value is 6.4 - 8.3 g/dl. The resident's albumin (a blood test used to measure the amount of protein in the blood and is used in part	F 314		

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to determine a person ' s nutritional status) level was within the normal range. The record lacked any further laboratory tests that included the resident's albumin or protein levels.

On 11-18-13 at 1:05 P.M. the hospice note documented the facility reported the need for a Broda chair and the resident's wounds needed to be addressed.

Continuous observation on 11-18-13 at 8:10 A.M. revealed the resident sat in his/her high back wheelchair with a yellow gel type cushion on the wheelchair. The resident sat at the dining table. The resident had scrambled eggs, 2 pieces of bacon, a slice of toast with butter and jelly cut in half, and 2 tall glasses with screw top lids and hard plastic straws. Both glasses were filled approximately one third of the way with fluid. The resident managed to unscrew the lid from one glass and spilled the liquid on the table and the floor. Direct care staff P cleaned the table and floor, and removed the glass from the table. Staff did not refill the glass or provide assistance with the resident's meal.

On 11-18-13 at 8:20 A.M., 8:25 A.M., 8:30 A.M., 8:35 A.M., 8:40 A.M., and 8:45 A.M., the resident continued to play with everything on the table. At 8:46 A.M. the resident made multiple attempts to tip the glass to drink from it, but was unable . At 8:52 A.M. dietary staff informed the resident they were going to take his/her napkin and placed it in a bag. The resident spilled the food remaining on his/her plate.

On 11-18-13 at 8:52 A.M. dietary staff informed the resident they were going to take his/her napkin and placed it in a bag. The resident

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spilled food from his/her plate onto the table and the plate was empty. The resident ate the bacon and half of the toast. The resident did not drink any fluids during the observation period.

On 11-18-13 at 8:55 A.M. direct care staff O informed the resident he/she was going to move the resident from the table. As direct care staff O attempted to move the resident, he/she grabbed to hold onto the table and when the resident was away from the table grabbed at another chair. Direct care staff O held the resident's hands to prevent him/her from grabbing anything else and positioned the resident in the living area.

On 11-18-13 at 8:59 A.M. direct care staff O and P took the resident to his/her room, placed a gait belt around the resident and lifted the resident to place a small pillow under his/her left hip. Direct care staff O stated it was to relieve pressure because the resident had a sore on his/her bottom.

On 11-18-13 at 1:01 P.M. observation revealed the resident sat in his/her high back wheelchair with a gel cushion. Direct care staff P sat beside the resident and attempted to feed the resident. The resident refused and played with the food and napkin. Direct care staff P handed the resident a tall glass with a screw top lid and hard plastic straw and the resident was not able to suck from the straw. Dietary staff removed the resident's plate with direct care staff P's permission. Direct care staff P did not offer the resident an alternate and did not assist the resident with his/her fluids at this time. When direct care staff P removed the resident from the table, the resident attempted multiple times to grab for the table.

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Observation on 11-18-13 at 2:50 P.M. revealed the resident laid in bed. The wound care physician entered the resident's room along with the hospice nurse and administrative nurse F. Administrative nurse F removed the resident's dressing from his/her left hip. Observation revealed the resident had 2 open areas, each with a whitish wound bed. The resident's perineal area was inflamed, bright red and had multiple whitish pinpoint areas. Administrative nurse F informed the physician the resident scooted in his/her wheelchair and that is how he/she developed the pressure ulcers. He/she informed the physician the wounds appeared worse, and the rash appeared like yeast today, unlike last week when he/she last saw the area. Administrative nurse F informed the physician hospice brought a Broda chair today to help relieve pressure to the left hip and staff offloaded the area with a pillow when the resident was in the chair. Administrative nurse F informed the physician the resident had constant incontinence and was difficult to keep a clean, dry dressing on the resident's wounds.

On 11-18-13 at 2:36 P.M. during an interview, direct care staff P stated resident was not able to state his/her toileting needs and was incontinent.

On 11-18-13 at 2:53 P.M. during an interview, consultant physician KK stated the wounds were pressure ulcers and did not want to provide aggressive treatment until the yeast infection cleared. He/she stated the wounds were not deeper than a stage 3, however because of the slough, they were unstageable.

On 11-18-13 at 3:09 P.M. during an interview, administrative nurse F stated he/she first saw the wounds on 11-12-13 upon his/her return from

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leave and because the edges of the wounds were rolling, he/she notified the wound physician to see the resident today.

On 11-18-13 at 3:23 P.M. during interview, licensed staff H stated prior to the development of the pressure ulcers the resident ambulated with a walker at times but had not ambulated since his/her last day of therapy in July 2013. He/she stated the resident had a reclining chair to relieve pressure also. Licensed nurse H stated there was not a change in the pressure ulcers since staff first observed them.

On 11-18-13 at 3:41 P.M. during interview, licensed nurse I stated staff placed a pillow under the resident's hip to offload the pressure when the resident was up in his/her wheelchair.

On 11-19-13 at 9:47 A.M. during an interview, direct care staff O stated the resident often refused cares that included bathing. He/she stated when staff bathed the resident and noticed an area, they informed the nurse and the nurse assessed the area at that time.

On 11-19-13 at 1:20 P.M. during an interview, administrative licensed staff D reviewed the resident's ADL sheet and acknowledged the resident did not receive any bathing from the facility during the month of November 2013 and received a bath from the hospice care attendant on 11-8-13.

On 11-19-13 at 3:50 P.M. during an interview, administrative nurse F stated staff placed the resident in a Broda chair yesterday and it belonged to the facility. He/she stated the resident had a cushion in the other chair also. He/she stated the resident had predisposing

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factors that made the resident a high risk for the development of pressure ulcers that included the use of diuretic medication and steroid medication for the treatment of the resident's cancer. He/she stated the resident had increased incontinence with the use of the diuretic medication.

The 11-1-10 facility provided Pressure Ulcer Prevention and Management Policy and Procedure documented all residents who were chairfast or had an alteration in skin were considered high risk for the development of pressure ulcers regardless of the risk assessment score and limited chair sitting for those individuals with ischial ulcers to one hour or less.

The facility failed to prevent the development of two unstageable pressure ulcers on the resident's left hip ischeal area and failed to provide timely interventions to promote wound healing.

- Resident #222's Admission Minimum Data Set (MDS) 3.0 dated 10/12/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, required extensive staff assistance with bed mobility, transfers, dressing, toilet use, and did not walk in the room/corridor. The MDS coded the resident was totally dependent upon staff with locomotion on/off unit, was independent with eating, and was occasionally incontinent of urine. The MDS identified the resident weighed 181 pounds and had not experienced a weight loss. The MDS recorded the resident had a Stage 1 or greater pressure ulcer, was at risk for the development of pressure ulcer, utilized a pressure ulcer device for the bed and chair and was not on a repositioning/turning program. The MDS did not identify the stage of the pressure ulcer.

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F 314	Continued From page 40 The resident's Pressure Ulcer Care Area Assessment (CAA) dated 10/16/13 documented the resident had an unstageable pressure ulcer behind his/her left ear and staff felt the ear piece on the resident's glasses was the cause of the pressure ulcer. The resident had oxy ears (cushioning to prevent pressure ulcers) on the left side on his/her ear piece to assist with decreasing pressure to the area. The CAA included the resident's buttock had MASD (moisture associated skin damage) upon admission, which since resolved. The CAA documented the resident was at risk for additional areas of skin breakdown due to multiple risk factors and the resident had one episode of urinary incontinence noted during the 7 day observation period. The CAA included the resident attempted to shift his/her weight when he/she sat in his/her wheelchair or recliner, but due to his/her limitations, he/she required extensive assistance from staff with turning/repositioning when in bed and in chair. The CAA included staff assisted the resident with turning/repositioning every 2 hours and as needed. The resident had a pressure reducing mattress in place on his/her bed and a pressure reducing cushion in place for his/her wheelchair. The resident's Activities of Daily Living (ADL) CAA dated 10/15/13 included the resident required extensive staff assistance with most of his/her daily care needs. The CAA included the resident had decreased mobility to his/her bilateral shoulders and experienced pain all over. The resident's care plan dated 10/16/13 addressed the resident had actual skin breakdown, required staff assistance with turning/repositioning, was continent of urine and	F 314		

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bowel and had an unstageable pressure ulcer behind his/her left ear. The care plan included the resident liked to sit in his/her electric recliner after each meal, the resident attempted to shift his/her weight by himself/herself when he/she sat in the recliner, and staff assisted the resident with repositioning/turning every 2 hours and as needed. The care plan included an entry dated 10/22/13 which included the resident had an unstageable pressure ulcer on his/her right scapula (shoulder blade) staff placed pillows to the back rest of the resident's Broda chair to offload the area and staff repositioned the resident every 1 1/2 to 2 hours, and off loaded the resident's heels when the resident was in bed. The care plan included staff did not leave the resident in the Broda after meals. An entry dated 11/13/13 included the resident had a deep tissue pressure ulcer on his/her left scapula.

The resident's nutrition care plan dated 10/23/13 addressed the resident was a nutritional risk related to multiple factors, he/she weighed 181 pounds, liked ice cream and staff should offer it at lunch and dinner. The care plan did not include the resident experienced a weight loss.

The resident's nursing admission assessment dated 10/1/13 documented the resident had a pressure ulcer on his/her left buttock that measured 3.0 centimeters (cm) by 2.0 cm and a pressure ulcer on his/her right buttock measuring 3.0 cm by 3.0 cm.

The resident's risk screening form dated 10/7/13 documented the resident had a scab behind his/her left ear which measured 1.0 cm by 1.0 cm.

The resident's risk screening form dated 10/14/13

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included the resident had a red area on the upper right of his/her back measuring 2.5 cm by 1.0 cm and a small scab area behind the resident's left ear.

The resident's risk screening form dated 10/20/13 documented the posterior (back part) aspect of the resident's right shoulder (shoulder blade) was open and the area measured approximately 0.5 cm in width and redness surrounded the area. The form included the resident's left shoulder blade reddened and the area of redness measured approximately 3.0 cm in width.

The resident's risk screening form dated 10/28/13 documented the posterior aspect of the resident's right shoulder had a bruise/scrape that measured 1.5 cm by 2.0 cm.

The resident's risk screening form dated 11/4/13 did not identify the resident continued with the pressure ulcers on his/her left and right buttock (the pressure ulcers healed between 10/28/13 and 11/4/13).

A wound evaluation flow sheet dated 11/11/13 documented the unstageable pressure ulcer on the posterior aspect of the resident's right shoulder measured 3.2 cm by 2.1 cm, depth undetermined, and the wound bed contained dark tan eschar (dead tissue). The sheet included the unstageable pressure ulcer on the posterior aspect of the resident's left shoulder measured 0.8 cm by 1 cm, and the wound bed was gray-dark and boggy.

The resident's risk screening form dated 11/18/13 documented the posterior aspect of the resident's right shoulder had an open area that measured 2.0 cm by 2.0 cm. The posterior aspect of the

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F 314	Continued From page 43 resident's left shoulder had a red area measuring 1.0 cm by 1.0 cm. A Physician's Visit Communication note dated 10/22/2013 and timed 10:48 A.M. documented staff received a signed communication sheet from the resident's physician which included for staff to clean the area on the resident's right shoulder with normal saline, apply triple antibiotic ointment, cover with Mepilex (a wound dressing that absorbs fluid), and change every 5 days. The note included the physician ordered for staff to apply Mepilex (dressing used to heal pressure ulcers) to the red area on the resident's left shoulder and change the dressing every 5 days. A physician's order dated 11/12/2013 (time unknown) included the resident had an unstageable pressure ulcer on his/her right scapula, ordered a Hydrocolloid dressing, and for staff to off load both scapulas with pillows when the resident was in the Broda chair. The order included the resident had a suspected deep tissue injury pressure ulcer on his/her left scapula. A physician's order dated 11/13/2013 (time unknown) included the resident may be in the Broda chair for meals only and do not leave the resident in the Broada chair after meals. Staff transferred the resident to the bed or the recliner after meals. On 11/13/13 the physician ordered the resident to receive Mighty Shakes (nutritional supplement that provided extra calories and protein). The resident's laboratory report dated 10/3/13 recorded the resident's albumin level (indicator of one type of protein in the blood) at 3.6	F 314		

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grams/deciliter (g/dL), normal reference range 3.4-4.8 g/dL. The report recorded the resident's protein level at 6.3 g/dL, normal reference level 6.4-8.3 g/dL.

Review of the resident's weights revealed the resident weighed 181 pounds on 10/2/13 and weighed 159 pounds on 11/15/13. This represented a significant weight loss of 22 pounds and/or 15 percent (%) of the resident's body weight. During this time the resident developed a nonstageable pressure ulcer on his/her right scapula and a suspected deep tissue pressure ulcer on his/her left scapula.

The resident's clinical record did not support the facility performed a tissue tolerance tissue to determine if the 1 1/2 to 2 hour turning/repositioning program was sufficient to minimize pressure on the resident's bony prominences.

On 11/18/13 at 7:30 A.M. the resident laid in bed on his/her back. Observation revealed a pressure relieving device on the resident's bed. The resident reported he/she had pressure ulcers on the posterior aspect of his/her shoulders.

Observation on 11/18/13 at 12:20 P.M. revealed the resident had an unstageable pressure ulcer on the posterior aspect of his/her right scapula measuring approximately 1.0 cm by 2.0 cm. Observation revealed the wound bed contained yellow slough (non-viable tissue). Observation also revealed the posterior aspect of the resident's left scapula had a pressure ulcer red in color with a dark center and the area measured approximately 0.5 cm by 0.5 cm.

On 11/18/13 at 1:17 P.M. the resident sat in the

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F 314	Continued From page 45 Broda chair in the dining room and staff assisted the resident with the lunch meal. Observation revealed no pillows in the Broda chair to offload the pressure ulcers on the scapula. Observation on 11/18/13 at 1:22 P.M. revealed the resident sat in his/her room in the Broda chair and with no pillows to offload the pressure ulcers. On 11/18/13 at 2:00 P.M., 2:10 P.M., 2:15 P.M., 2:30 P.M., 2:40 P.M., 2:50 P.M., 3:05 P.M., 3:16 P.M., 3:30 P.M., 3:45 P.M., 4:00 P.M. and 4:30 P.M. (duration of 2 hours and 30 minutes) the resident sat in the recliner, in his/her room without a change in position. On 11/1/13 at 9:30 A.M. the resident sat in the Broda chair at a dining room table. Observation revealed a small pillow behind the resident's back. On 11/19/13 at approximately 10:45 A.M. administrative nursing staff JJ stated the unstageable pressure ulcer on the resident's right scapula and the suspected deep tissue injury pressure ulcer on the resident's left scapula were facility acquired. Administrative nursing staff JJ stated the resident reported he/she required 2 staff to transfer him/her, therefore he/she had to sit for extended periods of times in the Broda chair and the resident felt that was the cause of the pressure ulcers. On 11/19/13 at approximately 11:50 A.M. physician staff JJ stated he/she was aware of the pressure ulcers. Physician staff JJ stated when the resident sat in the Broda chair staff should place large, fluffy pillows to offload the pressure.	F 314		

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F 314	Continued From page 46 On 11/19/13 at approximately 12:50 P.M. licensed nurse N stated the resident sat in a hunched position and when he/she sat in the Broda chair it caused pressure on the resident's back which contributed to the pressure ulcers. Licensed nurse N stated staff repositioned the resident at least every 2 hours, placed the resident in the recliner after meals and when the resident sat in the Broda chair, staff now placed pillows to offload the area. On 11/19/13 at approximately 1:08 P.M. direct care staff U stated staff repositioned the resident every 2 hours. On 11/19/13 at approximately 2:45 P.M. the resident stated prior to the development of the pressure ulcers, he/she expressed concerns regarding his/her back hurting when he/she sat in the Broda chair. The resident stated he/she required staff assistance with transfers and he/she spent an excessive amount of time in the Broda chair without repositioning. On 11/19/13 at approximately 3:10 P.M. administrative nursing staff G stated staff repositioned the resident every 2 hours and when the resident sat in the Broda chair staff placed pillows to offload the areas. Administrative nursing staff G stated the resident had a hunch in his/her back, the strap of the Broda chair placed pressure on that area which he/she felt contributed to the development of the pressure ulcers. The facility's Pressure Ulcer Prevention and Management Policy approved on 11/1/10 included all residents were assessed for risk of developing pressure ulcers and interventions initiated to prevent impaired skin integrity.	F 314		

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F 314	Continued From page 47 Residents admitted with or developed pressure ulcers received appropriate monitoring and treatment to promote healing. The facility promoted nutrition/hydration health which may include supplements. The facility failed to perform a tissue tolerance test, failed to timely implement nutritional supplements, failed to timely assess and determine if the Broda chair provided effective pressure relief, failed to reposition every 1 1/2 to 2 hours as planned for this resident dependent upon staff for transfers and bed mobility. - Resident #53's quarterly Minimum Data Set (MDS) dated 10/9/13 identified the resident had moderately impaired cognition and short and long term memory problems. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and did not walk in the room/corridor. The MDS coded the resident was totally dependent upon staff for locomotion on/off the unit, independent with eating, utilized a wheelchair and was frequently incontinent of urine. The MDS coded the resident did not have unhealed pressure ulcers, was at risk for the development of pressure ulcers, utilized a pressure relieving device for his/her wheelchair and was not on a turning/repositioning program. The resident's Activity of Daily Living Care Area Assessment (CAA) dated 2/14/13 documented the resident required staff assistance with activities of daily living. The resident's Urinary Incontinence CAA dated 2/14/13 documented the resident was incontinent	F 314		

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of urine, and staff toileted the resident every 2 hours.

The resident's Pressure Ulcer CAA dated 2/14/13 documented the resident was at risk for an alteration in skin integrity. The resident was unable to turn/reposition himself/herself without staff assistance, utilized a pressure reducing mattress in on his/her bed and sat in a Broda chair on a daily basis. The CAA included the Broda chair had lateral supports to assist the resident with sitting up straighter, was constructed with pressure relief as part of its design and therefore the resident did not require an additional pressure reducing cushion. Staff repositioned/turned the resident every 2 hours and as needed in bed and in the Broda chair. The resident shifted his/her weight some on his/her own as well. Licensed staff performed weekly skin assessments and staff monitored the resident's skin daily during daily care and bathing.

The resident's Braden Scale (scale used to predict the development of pressure ulcers) identified the resident scored 13 on 7/16/13 and 10/9/13. A score of 13 represented the resident was at moderate risk for the development of pressure ulcers.

The resident's care plan reviewed on 10/9/13 addressed the resident was at risk for alteration in skin integrity related to decreased mobility, cognitive impairment and requiring staff assistance with repositioning/turning. A licensed nurse assessed the resident's skin on a weekly basis, staff assisted the resident with repositioning/turning at least every 2 hours and as needed when in bed, chair, or recliner, the resident shifted his/her weight slightly on his/her own when sitting, and the Broda chair had a

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pressure reducing cushion built into the design.

A physician's visit communication form dated 11/13/2013 and timed 8:54 P.M. documented the wounds (moisture associated skin damage) to the resident's buttock and inner thigh had resolved, and for staff to discontinue the treatment. The form included for staff to assist the resident with repositioning/turning and to check the resident for incontinence every 2 hours.

The resident's risk screening form dated 11/16/13 documented the resident had a small open sore on his/her coccyx, and staff applied Nystatin ointment (used for treatment of yeast infections) to the area. The form did not document size, appearance, or the type of open sore.

The resident's clinical record did not support the facility performed a tissue tolerance test to determine if the 1 1/2 to 2 hour turning/repositioning program was sufficient to minimize pressure on the resident;s bony prominence's.

The resident's laboratory report dated 10/18/13 recorded the resident's albumin (indicator of protein) level at 3.5 grams/deciliter (g/dL), normal reference range 3.4-4.8 g/dL. The report recorded the resident's protein level at 6.8 g/dL, normal reference range 6.4-8.3 g/dL.

On 11/18/13 at 8:32 A.M. staff pushed the resident to a dining room table. Observation revealed the resident sat in a black wheelchair instead of the Broda chair per the plan of care.

On 11/18/13 at 8:44 A.M., 9:00 A.M. 9:20 A.M., 9:32 A.M., 9:50 A.M., 9:53 A.M. the resident sat in the black wheelchair. At 9:53 A.M. direct care

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F 314	Continued From page 50 staff U took the resident to the bathroom. At 10:10 A.M., 10:25 A.M., 12:10 P.M., 12:26 P.M., 12:40 P.M., 1:15 P.M., and 1:26 P.M. the resident sat in the black wheelchair. On 11/18/13 the resident laid in bed on his/her back at 2:00 P.M., 2:15 P.M., 2:30 P.M., 2:45 P.M., 3:00 P.M., 3:15 P.M., 3:30 P.M., 3:45 P.M., 4:00 P.M., 4:15 P.M. and 4:30 P.M. (duration of 2 hours and 25 minutes). Observation revealed a pressure relieving mattress on the resident's bed. On 11/19/13 at 7:45 A.M. direct care staff U entered the resident's room. Observation revealed the resident in bed on his/her back. Observation revealed the black wheelchair in the resident's room without a pressure relieving device. During interview with direct care staff T at that time, he/she stated the resident only used the black wheelchair when he/she went to to the beauty shop on Mondays. Direct care staff T stated the resident sat in the black wheelchair on 11/18/13 without a pressure relieving device. Direct care staff T stated he/she looked for a pressure relieving device for the wheelchair but could not find one. Further observation revealed the resident had a pressure ulcer on his/her right buttock that measured approximately 0.5 centimeters (cm) by 0.5 centimeters. Further observation revealed the wound base had some yellow slough (non-viable tissue). Direct care staff U stated he/she observed the open area when he/she showered the resident last week and reported the open area to the nurse. Direct care staff U and direct care staff NN transferred the resident from the bed to the toilet via a sit to stand lift. Direct care staff U stated the resident's incontinent brief was wet with urine. On 11/19/13 at approximately 10:45 A.M.	F 314		

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administrative nursing staff JJ stated he/she was not aware the resident had a pressure ulcer on his/her right buttock.

On 11/19/13 at approximately 12:50 P.M. licensed nurse N stated he/she was not aware the resident had a pressure ulcer. Licensed nurse N stated licensed nurses noted on the 24 hour report any alterations in skin. Licensed nurse N reviewed the 24 hour reports and stated the 24 hour reports did not reveal the resident had a pressure ulcer. Licensed nurse N stated staff repositioned the resident at least every 2 hours.

Interview on 11/19/13 at 1:08 P.M. direct are staff T reported staff repositioned the resident at least every 2 hours.

On 11/19/13 at approximately 3:00 P.M. administrative nursing staff JJ was in the resident's room. Administrative nursing staff JJ stated the resident had a Stage 3 pressure ulcer on his/her right buttock measuring 0.4 cm by 0.3 cm by 0.1 cm . Administrative nursing staff JJ stated the resident's left buttock was red and non blanchable. Administrative nursing staff JJ stated the resident's left buttock and right buttock pressed together which created pressure and the Stage 3 pressure ulcer.

On 11/19/13 at approximately at 3:10 P.M. administrative nursing staff G stated he/she was not aware the resident had a Stage 3 pressure ulcer. Administrative nursing staff G stated the resident should have pressure relieving device in his/her wheelchair and staff should reposition the resident at least every 2 hours.

On 11/20/13 at approximately 3:15 P.M.

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F 314	Continued From page 52 physicians OO and PP stated neither physician was aware the resident had a pressure ulcer. The facility's Pressure Ulcer Prevention and Management Policy approved on 11/1/10 included all residents were assessed for risk of developing pressure ulcers and interventions initiated to prevent impaired skin integrity. Residents admitted with or developed pressure ulcers received appropriate monitoring and treatment to promote healing. The facility promoted nutrition/hydration health which may include supplements. The facility to perform a tissue tolerance test, failed to timely implement treatment, failed to ensure the resident's wheelchair had a pressure relieving device and failed to reposition the resident every 1 1/2 to 2 hours as planned for this resident dependent upon staff for transfers and bed mobility, who developed a Stage 3 pressure ulcer on his/her right buttock.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility identified a census of 186 residents. The sample included 22 residents. Based on	F 315		

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observation, interview, and record review the facility failed to provide complete perineal care, and failed to monitor and assist the resident with fluid consumption for 1(#196) of 3 residents identified with incontinence and with a urinary tract infection (UTI).

Findings included:

- Resident #196's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-17-13 documented the resident with short and long term memory loss and severe cognitive impairment. The resident required extensive staff assistance with activities of daily living (ADLs) and limited assistance of staff with eating. The resident was incontinent of bowel and bladder, had physical and verbal behaviors toward others, wandered and rejected cares on a daily basis.

The Urinary Incontinence Care Area Assessment (CAA) dated 7-24-13 documented the resident was incontinent, he/she was on a prompting program but changed to a habit program (toileting program of regular trips to the bathroom to avoid accidents), and wore pull up briefs.

The 10-25-13 care plan documented the resident was at risk for functional, stress, urge and overflow urinary incontinence. The resident was also at risk for frequency, retention, and urinary tract infections (UTI) related to his/her dementia (progressive mental disorder characterized by failing memory, confusion) and a meningioma (benign brain tumor). The care plan documented the resident alerted staff occasionally when he/she needed to toilet and participated in his/her

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toileting program. The care plan directed staff to toilet the resident when he/she tried to get up without assistance, and respond quickly when the personal alarm sounded to assist with toileting needs. The care plan documented the resident told staff when he/she needed to "tee, tee", which meant he/she needed to toilet. The care plan directed staff to check and change the resident every 2 hours, and provide incontinence care.

On 11-13-13 the care plan documented the resident with a UTI and directed staff to observe the resident for an elevated temperature.

The 7-26-13 Urinary Incontinence Assessment documented the resident voided at least 3 times daily without incontinence and was not incontinent of bowel. The resident ambulated to the bathroom with assistance of one staff, he/she was aware of the need to void and had the potential for habit, prompted, or scheduled toileting program.

The Bladder Training Flowsheet dated 11-8-13 through 11-10-13 documented the resident was incontinent of urine and bowel.

On 11-8-13 the laboratory urine culture documented the resident had escherichia coli (a bacterial infection) and the physician prescribed Bactrim (an antibiotic) double strength (DS) twice daily for 10 days for the resident's UTI.

Continuous observation on 11-18-13 at 8:10 A.M. revealed the resident sat in his/her high back

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wheelchair and had a yellow gel type cushion in the wheelchair. The resident sat at the dining table. The resident had scrambled eggs, 2 pieces of bacon, a slice of toast with butter and jelly cut in half, and 2 tall glasses with screw top lids and hard plastic straws. Both glasses were filled approximately one third of the way with fluid. The resident managed to unscrew the lid from one glass and spilled the liquid on the table and the floor. Direct care staff P cleaned the table and floor, and removed the glass from the table. Staff did not refill the glass or provide assistance with the resident's meal.

On 11-18-13 at 8:15 A.M. the resident took a bite of toast or bacon then played with everything on the table. The resident attempted to get a drink from the glass, but could not maneuver it to his/her mouth to get a drink.

On 11-18-13 at 8:20 A.M., 8:25 A.M., 8:30 A.M., 8:35 A.M., 8:40 A.M., and 8:45 A.M., the resident continued to play with everything on the table. At 8:46 A.M. the resident made multiple attempts to tip the glass to drink from it, but was unable . At 8:52 A.M. dietary staff informed the resident they would take his/her napkin and place it in a bag. The resident spilled the food remaining on his/her plate.

On 11-18-13 at 8:55 A.M. direct care staff O informed the resident he/she was going to move the resident from the table. As direct care staff O attempted to move the resident, he/she grabbed to hold on to the table and when staff moved the resident away from the table, he/she grabbed at another chair. Direct care staff O held the

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resident's hands to prevent him/her from grabbing anything else and positioned the resident in the living area. Staff did not offer any fluids to the resident at this time.

On 11-18-13 at 8:59 A.M. direct care staff O and P took the resident to his/her room, placed a gait belt around the resident and lifted the resident to place a small pillow under his/her left hip. Direct care staff O stated it was to relieve pressure because the resident had a sore on his/her bottom. Staff did not offer any fluids to the resident at this time.

On 11-18-13 at 1:01 P.M. observation revealed the resident sat in his/her high back wheelchair with a gel cushion. Direct care staff P sat beside the resident and attempted to feed the resident. The resident refused and played with the food and napkin. Direct care staff P handed the resident a tall glass with a screw top lid and hard plastic straw and the resident was not able to suck from the straw. Dietary staff removed the resident's plate with direct care staff P's permission. Direct care staff P did not offer the resident an alternate and did not assist the resident with his/her fluids at this time. When direct care staff P removed the resident from the table, the resident attempted multiple times to grab for the table.

Observation on 11-18-13 at 2:15 P.M. revealed direct care staff O and Q transferred the resident from his/her wheelchair to the bed. Direct care staff Q removed the resident's pants and brief and revealed the resident's perineal area was red and inflamed. Direct care staff Q wiped the resident's genital area but did not wipe the entire

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area the residents' soiled brief covered. Staff applied "Clear Moisture Barrier" cream to the resident's genital area where the rash was located. At this time, direct care staff Q stated they were supposed to put it on the resident with each incontinent episode.

On 11-18-13 at 2:36 P.M. during an interview, direct care staff P stated resident was not able to state his/her toileting needs and was incontinent.

On 11-19-13 at 9:47 A.M. during an interview, direct care staff P stated the resident used the glass with the screw top lid because he/she spilled fluids, but was not sure the resident knew how to use it. He/she stated the cup was probably too heavy for the resident to use. He/she stated dietary staff provided all the fluids for residents and the resident received most of his/her fluids from the nurse with medication. He/she stated he/she offered the resident fluids with cares and with snacks. He/she stated when the resident was incontinent, he/she cleaned the entire area covered by the brief. He/she stated he/she reported to the nurse if the resident was not drinking fluids.

On 11-18-13 at 3:23 P.M. during interview, licensed staff H stated staff checked the resident every 1 to 2 hours, was aware of the redness on the resident perineal area and staff used "Clear Moisture Barrier" cream with each incontinent episode.

On 11-19-13 at 10:24 A.M. licensed nurse I

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F 315	Continued From page 58 stated he/she gave the resident medication about every 2 hours and the resident received fluid at that time. He/she stated the resident was able to drink independently with the little cup of water he/she received with medications. Licensed nurse I stated staff offered the resident fluids with cares and at meal time. He/she stated staff provided the screw top cup because the resident spilled liquids. He/she was unaware the resident was not able to drink from the cup. Licensed nurse I also stated staff cleaned the entire area the brief covered when they provided perineal care. The January 2009 facility provided Habit Training Protocol documented staff provided skin care with each incontinent episode. The facility failed to provide complete perineal care, and failed to offer fluids for this cognitive impaired resident who had a pressure ulcer and a UTI.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 186 residents. The sample included 22 residents. Based upon observation, record review and interviews the facility failed to implement interventions to	F 323		

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minimize falls for 2 (#164, #37) of 3 residents sampled for falls, and failed to ensure a safe environment for all residents by failing to secure and/or monitor doors which led to the stairwells.

Findings included:

- Review of resident #37's quarterly Minimum Data Set (MDS) dated 10/30/13 identified the resident had moderately impaired cognition, short and long term memory problems, required limited staff assistance with bed mobility, transfers, walking in the room/corridor, locomotion on/off unit, and personal hygiene. The MDS coded the resident required extensive staff assistance with dressing, toilet use, and staff supervision with eating. The MDS identified the resident was not steady but able to stabilize without staff assistance when moving from seating to standing, walking, turning around and facing the opposite direction, moving on/off the toilet and surface to surface transfers. The MDS identified the resident did not use mobility devices,and fell once since admission or the prior assessment.

The resident's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 3/13/13 documented the resident needed staff assistance with his/her ADLs. The resident ambulated without assistive devices other than a gait belt.

The resident's Fall CAA dated 3/13/13 documented the resident did not fall recently, was at risk for falls due to his/her unsteady gait, and had a history of falls. The CAA included the resident was on the the Falling Star Program, and staff assisted the resident with ambulation and transfers. The CAA included the resident had a low bed and a mat on the floor by his/her bed.

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The resident's fall risk assessment dated 8/21/13, 10/19/13, and 11/11/3 identified the resident was at moderate risk for falls.

The resident's care plan dated 10/24/13 included the resident was at risk for falls due to a history of falls. The resident received restorative nursing, utilized a wheelchair for long distances if needed or when the resident felt weak. The care plan addressed the resident was on the falling star program, staff provided visual cues to increase the resident's safety awareness, and staff placed a mat on the floor on the right side of the resident's bed.

A post fall supplemental plan of care dated 11/11/13 included staff placed the resident in the center of the bed.

A nurse's note dated 11/28/2012 and timed 5:35 P.M. documented at approximately 2:45 P.M. the resident sat on the floor mat by his/her bed. The note included the resident stated he/she got up to fold a blanket. Interventions included staff provided visual observance every 30 minutes and staff would bring the resident to the television area if the resident was awake in his/her room.

A nurse's note dated 8/21/2013 and timed 10:16 P.M. documented at 9:45 P.M. the resident yelled for help, staff entered the room and the resident sat on the floor mat by his/her bed. The resident stated he/she was asleep and slid out of the bed. The resident sat on his/her bottom with his/her legs bent with his/her feet under him/her.

On 11/13/13 at 3:28 P.M. and 3:57 P.M. the resident laid in a low bed, a fall mat on the left side of the resident's bed, and the resident was not centered in the bed. Observation revealed the

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F 323	Continued From page 61 resident's knees touched the side of the bed. On 11/18/13 at 11:25 A.M. the resident laid in bed on his/her left side, the resident was not centered, the resident's knees in a curled position, and touched the edge of the bed. Further observation revealed no fall mat on either side of the resident's bed. On 11/19/13 at approximately 2:00 P.M. licensed nurse LL stated the resident needed frequent reminders to stay in the center of the bed. Staff placed a mat on the left side of the resident's bed, and made frequent observations and reminded the resident to lay in the center of the bed. Licensed nurse LL stated most of the resident's falls occurred when the resident fell out of bed. On 11/19/13 at 2:36 PM direct care staff T stated the resident utilized a low bed with a fall mat on the left side. Direct care staff T stated the resident had a tendency to scoot to the edge of bed and staff frequently checked on the resident to ensure the resident was in the center of the bed. On 11/19/13 at approximately 3:30 P.M. administrative nursing staff G stated the resident had a history of falling out of the bed and staff frequently checked on the resident to ensure he/she was centered in the bed. The facility failed to ensure staff placed the fall mat consistently on the floor when the resident was in bed, and also failed to ensure the resident was centered in the bed as planned for this resident with a history of falls. - On 11/12/13 during the initial tour of the facility	F 323		

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F 323	Continued From page 62 at approximately 9:30 A.M. observation revealed an exit door was not monitored or locked. Further observation revealed when the door opened it led to a stairwell. On 11/12/13 at approximately 11:45 A.M. observation revealed the facility's utility door which led to the dietary department was not monitored or locked. On 11/13/13 at approximately 10:30 A.M. observation revealed the facility utility door which led to the dietary department was not monitored or locked. On 11/13/13 at approximately 12:49 P.M. observation revealed the above door not monitored or locked. Further observation revealed the door lead to central supply and dietary. Further observation revealed an unlocked/unmonitored door that led to a parking lot. On 11/19/13 between 5:30 P.M. and 6:00 P.M. administrative staff A confirmed the above doors were not monitored or locked. The facility failed to ensure the environment was safe for all residents by maintaining doors which led to stairwells were locked and/or monitored. . - Resident #164's November 2013 electronic medical record stated the resident lived on a secure memory care unit and had a diagnosis of psychosis with behavioral disturbance (any major mental disorder characterized by a gross impairment in reality testing, that could alter an individual's behavior) and lack of coordination.	F 323		

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F 323	Continued From page 63 The 14 day Minimum Data Set 3.0 (MDS) assessment dated 9/14/13 documented the resident had severely impaired cognition, sometimes rejected cares and had daily wandering behavior. The MDS recorded the resident required extensive assistance of two staff members with bed mobility and transfers and extensive assistance of one staff member with dressing, toileting, personal hygiene, eating and ambulating on and off the unit. The MDS did not address the resident's fall history. The Care Area Assessment (CAA) for falls dated 9/6/13 recorded the resident had one fall since admission, where staff found him/her crawling in a peer's room. Staff placed the resident on the physician's list for medication review and he/she was at continued risk due to medical diagnoses. Review of the resident's initial fall assessment dated 8/30/13 recorded the resident with a score of 20, which indicated a high risk for falls. Review of the clinical record and fall investigations revealed the resident experienced non-injury falls on 9/3/13, 10/23/13, 10/24/13, 10/29/13, 10/31/13, 11/2/13, 11/6/13, 11/12/13, and 11/16/13. The resident's care plan dated 9/19/13 recorded the resident at risk for falls and directed staff to assist the resident with ambulation when feeling weak, keep resident up until last and assist him/her to bed when he/she was ready, and on 11/13/13 added a personal safety alarm when the resident was in bed. The care plan lacked interventions from the fall investigations dated 10/19/13, 11/12/13, and	F 323		

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F 323	Continued From page 64 11/13/13 the resident used a low bed with right side landing mat, the use of non-slip socks at all times and 15 minute checks. Observation on 11/18/13 at 1:00 P.M. revealed the resident walked with staff toward his/her own room, turned around and walked back to the activity area (unattended) with his/her right tennis shoe not fully on (the shoe heel was pushed down in the back). The resident then stood unattended in the activity room. Observation on 11/18/13 at 3:15 the resident sat in a chair in the activity area. At 3:30 P.M. the resident walked to his/her room and back to the activity area where residents were playing Bingo, but staff did not encourage him/her to participate or assist him/her to ambulate. At 3:45 P.M. the resident walked toward his/her room and went into another residents room, exited, and he/she came to the television area, and fumbled with the television cable. On 11/18/13 at 4:00 P.M. licensed nurse NN stated he/she did not work with the resident often, but the resident did become restless at night and crawled out of bed, generally he/she wanted something to eat, drink or go to the bathroom. The resident was sometimes continent of bladder sometimes and sometimes not. This happened quite a bit at night and then it started during the day. Licensed nurse NN added the resident did not fall or crawl out of bed on his/her shift. The facility policy titled Fall Prevention and Management revised 2012 recorded: "The interdisciplinary team will develop a plan for services to improve or maintain the residents standing and sitting balance and other interventions to reduce the residents risk for falls.	F 323		

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F 323	Continued From page 65 The plan will include specific information about the residents routine and personal habits that may place the resident at risk for falls." The facility failed to ensure adequate supervision and assistance to prevent falls for this cognitively impaired dependent resident.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This Requirement is not met as evidenced by: The facility had a census of 186 residents. Based on observation, record review, and interviews the facility failed to ensure a medication error of less than 5 percent (%) which affected 1 (#26) of 6 residents observed for medication administration which resulted in a medication error rate of 7.692 percent. Findings included: - On 11/13/13 at 8:00 A.M. direct care staff MM set up resident #26's medication. Observation revealed direct care staff MM placed (2) 500 milligrams (mg) of Tylenol (used to treat pain) in a medication cup. The surveyor asked for the total dosage of Tylenol he/she placed in the cup and direct care staff MM stated 1,000 mg. Direct care staff MM then referred back to the electronic Medication Administration Record and stated the resident should receive 500 mg of Tylenol and not 1,000 mg. Direct care staff MM removed 1 of the 500 mg of Tylenol from the cup. After direct care staff MM administered the resident's oral	F 332		

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	175340	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

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F 332	Continued From page 66 medications, direct care staff MM had the resident inhale 1 puff of the ProAir HFA (used to treat breathing problems) 90 mcg (micrograms) inhaler. Review of the resident's Physician Order Sheet dated 10/18/13 revealed the resident's physician orders were for the resident to inhale 2 puffs of the ProAir inhaler four times a day and a physician's order for 500 mg of Tylenol every morning. On 11/13/13 at approximately 8:15 A.M. direct care staff MM stated the resident should inhale 2 puffs of the inhaler. The facility failed to administer this resident's medications as ordered.	F 332		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed	F 353		

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F 353	Continued From page 67 nurse to serve as a charge nurse on each tour of duty. This Requirement is not met as evidenced by: The facility identified a census of 186 residents. Based on observation and interview the facility failed to provide sufficant nursing staff to meet the resident's needs for two of four days of on-site survey. Findings included: - During confidential interviews with multiple residents dated from 11-12-13 to 11-13-13 revealed the residents verbalized having to wait a long time for care, assistance, and felt the facility was short staffed on all shifts. Observation on 11-18-13 at 9:34 A.M. the wireless call light monitor displayed resident #152's call light was on for 12 minutes and 30 seconds, and #242's call light was on for 9 minutes and 29 seconds. Observation on 11-18-13 at 3:36 P.M. the wireless call light monitor displayed resident #127's call light was activated for 9 minutes and 23 seconds and at 3:39 P.M. the call light was activated for 12 minutes and 11 seconds. Observation on 11-19-13 at 7:33 A.M. the wireless call light monitor revealed resident #1's call light was activated for 20 minutes and 35 seconds. Observation on 11-19-13 at 8:38 A.M. the wireless call light monitor revealed resident #21's call light was activated for 19 minutes and 43 seconds.	F 353		

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F 353	Continued From page 68 Interview on 11-19-13 at 12:50 P.M. with direct care staff U revealed certified nursing assistant staff carried pagers that alerted them when residents activated their call light and staff should respond as soon as possible. Interview on 11-19-13 at 12:54 P.M. with direct care staff V revealed sometimes we were short staffed. If someone called in, our manager found staff or pulled staff from another unit. Interview on 11-19-13 at 12:50 P.M. with licensed staff N revealed staff should respond to call lights as soon as possible. At 2:50 P.M. stated sometimes we were short staffed but they got replacement staff. The facility failed to provide a policy and procedure regarding insufficient staffing. The facility failed to have sufficiant nursing staff available to meet residents needs for nursing care in a manner and in an enviroment which promoted each resident's physical, mental, and psychosocial well-being.	F 353		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 69 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility identified a census of 186 residents. Based on observations, record review, and interview the facility failed to provide timely education when staff identified a pattern of infections that included conjunctivitis (inflammation of the eye lid that may be contagious) and urinary tract infections (UTI) on 2 units. Findings included: - On 11-18-13 at 4:47 P.M. during record review of the infection control program documented in	F 441		

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F 441	Continued From page 70 May 2013, 6 residents on a secured unit had UTIs. Further review of the record lacked evidence licensed staff provided education at the time the infections occurred. In July 2013, the infection control program documented staff identified 5 residents on one unit with conjunctivitis and received antibiotics. Further review of the record lacked evidence licensed staff provided education at the time the infections occurred. On 11-18-13 at 4:17 P.M. administrative licensed staff G could not state if staff were educated with each pattern of infection. He/she said when staff identified a particular infection was a pattern on a certain unit, then staff provided education. He /she stated with UTIs, staff completed audits which included monitoring staff during cares to make sure residents received the appropriate perineal care, encouraged to drink fluids, and staff completed appropriate handwashing with cares. On 11-19-13 at approximately 4:00 P.M. the facility provided documentation staff provided handwashing education and audits to reflect the UTIs on the secured unit in May 2013. However staff received the education beginning 5-29-13 and ended 7-10-13. The facility provided documentation staff were educated on handwashing for conjunctivitis in July 2013. However, only 6 staff received education with handwashing. The January 2007 facility provided Infection Control Policy and Procedure documented staff consulted all the teams in the facility when staff identified infection control issues.	F 441		

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F 441	Continued From page 71 The facility failed to provide timely education following identification of a break in infection control concerning residents with two separate occurrences of patterned infections. - Observation on 11/19/13 at 1:49 P.M. revealed laundry staff X walked down the hallway on the Norwich unit. He/she had 6 folded clothing items and approximately 3 to 4 clothing items on hangers and the folded items rested directly against his/her clothing. Further observation revealed laundry staff Y walked behind laundry staff X with approximately 4 folded clothing items and a couple of clothing items on hangers. Observation revealed laundry staff X held the folded clothing items up against his/her clothing, Laundry staff X and Y entered a shared resident's room and placed the items in the resident's closets and dressers. Observation on 11/19/13 at approximately 1:54 P.M. laundry staff Y carried approximately 5 clean clothing items against his/her clothing and the top items were in direct contact with his/her chin. Interview on 11/19/13 at approximately 1:49 P.M. Laundry staff X confirmed the items were clean resident clothes the facility laundered and were returning the clean items to the resident rooms. Laundry staff X stated staff should not hold clean laundered items against his/her clothing. An interview on 11/19/13 at 1:54 P.M. revealed Laundry staff Y confirmed the clean clothing items were against his/her clothing and under his/her chin. The facility failed to handle clean laundry in a sanitary manner.	F 441		